Long-Term Care Insurance (LTCI) Program Change Form

Mail completed form to:
Long-Term Care Insurance Program
Bowling Green Station
P.O. Box 707
New York, NY 10274
Web site: http://nyc.gov/olr

LONG-TERM CARE
Home Care | Nursing Facility Care | Adult Day Health Care | Informal Care

I. Type of Change - Please ☑ check the type of change(s) that apply and complete the applicable sections below.

❑ Name/Personal Information* ❑ Address/Phone Number ❑ Agency ❑ Employment Status*/Billing Option
❑ Payroll Cycle ❑ Cancel Coverage *PLEASE PROVIDE LEGAL DOCUMENTATION OR A LETTER FROM YOUR AGENCY.

Please contact MetLife at 1-800-438-6388 to obtain the appropriate forms for Long-Term Care Insurance coverage changes.

II. PARTICIPANT INFORMATION

Social Security Number | Last Name | First Name | M

Home Mailing Address - Number and Street | Apt. No.

City | State | Zip Code | Sex ❑ M ❑ F

Area Code | Home Telephone No. | Area Code | Work Telephone No. | Date of Birth (MM/DD/YY) | Martial Status ❑ M ❑ S ❑ D ❑ W

III. NYC Employee/Retiree Name: ❑ Active ❑ Retired

Employee's Date of Hire/Retirement: ____/____/____

Social Security Number: _____

Relationship to Employee/Retiree:
❑ Self ❑ Spouse/Domestic Partner ❑ Adult Child
❑ Surviving Spouse/Domestic Partner
Date of Employee's Death: ____/____/____
❑ Employee's Parent or Parent-in-law
❑ Employee's Grandparent or Grandparent-in-law

IV. Current/New Agency: _____

Previous Agency: (PLEASE PROVIDE ONLY IF CHANGING AGENCIES): _____

V. Payroll Cycle (FOR ACTIVE EMPLOYEE AND SPOUSE/DOMESTIC PARTNER OF AN ACTIVE EMPLOYEE ONLY):
❑ Weekly ❑ Bi-weekly ❑ Semi-monthly (DOE Q BANK EMPLOYEES ONLY)

VI. Employment Status:
❑ Resigned: Effective date of resignation: ____/____/____
❑ Retired: Retirement date: ____/____/____ Agency Retired From: _____
❑ Unpaid leave of absence: Start date: ____/____/____
❑ Return from unpaid leave of absence: Active return date: ____/____/____

VII. Billing Option:
a: For active Employee and Spouse/Domestic Partner: (PLEASE SIGN AUTHORIZATION SECTION OF THIS FORM.)
❑ Resume payroll deduction (RETURNED FROM UNPAID LEAVE)
b: For all other Participants:
❑ Direct Billing (NOT APPLICABLE FOR ACTIVE EMPLOYEE/SPOUSE/DOMESTIC PARTNER)

VIII. Coverage Cancellation: (PLEASE SIGN AUTHORIZATION SECTION OF THIS FORM.) ❑ I wish to cancel my LTCI coverage*

* **Your coverage will end on the last day of the month in which Metlife is notified.**

IX. Change Authorization:
I authorize the LTCI Administrator to make the appropriate LTCI coverage changes and to release other information to the LTCI Carrier of this program.

Participant Signature: _____ **Date:** _____

Do Not Write in This Box		Initial	Process Date	Date of Foward to LTCI Carrier	Effective Date (MM/DD/YYYY)	
	LTCI Database		/ /	/ /	/ /	N:\LTCI_ChangeFrm.indd 9/14